Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED					
			A. BUILDING: _							
		N089001	B. WING		02/25/2015					
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE						
BREWSTER HEALTH CENTER 1001 SW 29TH ST TOPEKA, KS 66611										
(X4) ID	SUMMARY STA	PROVIDER'S PLAN OF CORRECTION	N (X5)							
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE					
S 000	INITIAL COMMENTS		S 000							
	The following citations Health Resurvey.	s represent the findings of a								
S 970 SS=F	26-40-302 (g)(i)(ii)(iii) P E - Nursing facility support systems		S 970							
	(G) If a nursing facility meet the requirement	y uses a wireless system to sof paragraphs								
	<ul> <li>(i)(1)(A) through (E), all of the following additional requirements shall be met:</li> <li>(i) The nursing facility shall be equipped with a system that records activated calls.</li> <li>(ii) A signal unanswered for a designated period of time, but not more than every three</li> </ul>									
	minutes, shall repeat and also be sent to another workstation or to staff that were not designated to receive the original call.									
		ot interfere with or disrupt								
		ators, and any other medical eceive only signals initiated								
	from the manufacture									
	This REOLIBEMENT	is not met as evidenced								
	by:									
	K.A.R. 26-40-302 (g)	(i) (ii) (iii)								
		census of 95 residents with								
	5 neighborhoods. Ba interview and record in	review the facility failed to								
	ensure the wireless c in 3 minutes if not ans	all system escalated within swered.								
		•								

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

PRINTED: 02/26/2015 FORM APPROVED

Kansas Department on Aging

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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE				
S 970	from 8:15 A.M 8:45 call system pagers ale a resident activated the recalls alerted the direct two minutes before established.  An interview on 2/19/staff I confirmed that a direct care staff immer minute increments, at pager was alerted and telephone.  An interview on 2/23/administrative nurse I rang in two minutes ir staff and after 7 minururse pager.  The facilities Nurse A revision date of 9/16/activation of a call light Kaizen (direct care st minutes until it is answinutes the nurse pheminutes the Assistant managers, Director of get alerted by email.  The facility failed to e notified additional staff	A.M., revealed the wireless erted direct care staff when heir call light. Subsequent ect care staff again every scalating any other staff.  15 at 3:55 P.M., Licensed the call system alerts the diately and then in two fer 6 minutes the nurse of the nurse 's station.  15 at 4:50 P.M., D revealed the pager system increments to the direct care tes it rang to the charge.  14 revealed that on the an alert goes to the faff) pagers every two wered and cleared. At 7 one gets an alert, and at 9	S 970						